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via electronic mail and USPS delivery

Ms. Janette Lopez
Chief Deputy Director
California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814

RE: EVALUATION OF HEALTH NET OF CALIFORNIA (HMO) MEDICAL LOSS RATIO SUBMISSION

Dear Ms. Lopez:

The Department of Managed Health Care (DMHC) hereby provides the Managed Risk Medical Insurance Board (MRMIB), Healthy Families Program (HFP) with the following report regarding the evaluation of Health Net of California (HMO) (HN-HMO) HFP loss ratio submission for the period July 1, 2007 through June 30, 2008. This report outlines the project objectives, methodology and results.

I Objectives: The purpose of the loss ratio evaluation was to evaluate the underlying payments supporting the amount reported as benefits provided to HFP subscribers and reported by HN-HMO.
As part of this evaluation, DMHC performed the following:

A Determined whether 100% of the children who received services paid by HN-HMO were enrolled in the HFP at the time the services or capitated coverage were provided

B Summarized the total capitation and benefit payments within the detailed data provided by HN-HMO and compared the total payments to the amount reported on Schedule 6 submitted by HN-HMO

C Summarized the total payments made by HN-HMO for the HFP subscriber, and based on the steps above, recalculated the loss ratio and compared it to the loss ratio submitted by HN-HMO on Schedule 6.

To achieve the objectives outlined above, DMHC performed data analysis on information provided by MRMIB and HN-HMO and corresponded with management personnel at HN-HMO. Primary contacts at HN-HMO were David Meadows, VP State Health Programs; Afzal Shah, Director of Actuarial Services; Marie Hidalgo, Supervisor of Financial Planning and Daria Baker, Compliance and Reporting Manager.

II Methodology

A Determined whether 100% of the children who received services paid by HN-HMO were enrolled in the HFP at the time the services were provided.

1 DMHC obtained electronic files containing payments made for HFP subscribers. Additionally, the Department obtained electronic files from MRMIB of all children eligible for whom payments were made for benefits as an HN-HMO subscriber during the period of July 1, 2007 though June 30, 2008.

2 Using the two files, DMHC compared the Client Index Number (CIN) and Date of Service on HN-HMO files to determine if there were any payments made by HN-HMO for subscribers that were not eligible for benefits according to the eligibility file received from MRMIB.

Table 1 – Capitation and Fee for Service payments for individuals that were not listed as eligible members per the data files provided by Maximus for the service periods under examination.

Table 1 (Ineligible Expenditures)

	Data Base Total		Ineligible Data		
Claims/Capitation Payments Category	**Number of claims/services**	**Amount**	**Number of claims/services**	**Amount**	**Percent Error on Amounts**
Capitation	6,316,892	$48,787,774	498,533	$139,219	0.29%
Fee-for-Service Payments Professional	93,442	$10,189,193	308	$32,272	0.32%
Fee-for-Service Payments Institutional	30,325	$33,885,388	131	$136,596	0.40%
Pharmacy	298,717	$10,157,548	1,424	$48,605	0.48%

Notes for Table 1: FFS, Capitation and Pharmacy payment mismatches identified during the examination were determined to be immaterial by the examiner and were not proposed as adjustments for the audit.

B Summarized the total benefit payments within the detailed data provided by HN-HMO and compared the total payments to the amount reported on Schedule 6 submitted by HN-HMO.

Using electronic files and paper documentation received from HN-HMO in Section II above, and HN-HMO Schedule 6 loss ratio submission provided by MRMIB, DMHC compared the

total of the payments on the electronic files and paper documentation to the data reported on Schedule 6.

This analysis represents payments made by the Plan to their contracted providers and not payments made by MRMIB to the Plans.

Table 2
Difference between Sch 6 reported amounts and Database Details[1]

Description	Sch 6	Plan Data	Difference Overaccrued/ (Underaccrued)	Percent Error
Physician claims	$10,917,034	$10,189,193	$727,841	7.14%
Physician Capitation	$37,705,021	$37,567,598	$137,423	0.37%
Hospital claims	$36,474,646	$33,885,388	$2,589,258	7.64%
Hospital Capitation	$4,230,366	$4,226,956	$3,410	0.08%
Pharmacy	$9,649,178	$9,926,516	($277,338)	-2.79%
Other Medical Services – Capitated[2]	$536,340	$6,089,295	($5,552,955)	-91.19%
Other Medical Services - Non-Capitated[2]	$4,988,543		$4,988,543	N/A

Note 1: The data base provided by HN-HMO was analyzed based on the period of service and has been determined the most accurate measure of medical expense for the period of the examination. The data base included a review of costs identified through August 31, 2009 after the exam period to ensure capture of all amounts which would have been identified via accruals/IBNRs.

Note 2: Other Medical Services Capitated include Behavioral Health Capitation and Chiro Capitation.

C Summarized the total payments made by HN-HMO for the HFP subscriber, and based on the steps above, recalculated the loss ratio and compared it to the loss ratio submitted by HN-HMO on Schedule 6

Table 3
Detailed reconciliation of detailed data files to Schedule 6

	Category	Reported On Schedule 6	Balance Per DMHC Review	Variance Overaccrued/ (Underaccrued)
	Subscriber Months	1,394,520	1,399,201	(4,681)
1	Premium Payments from State	$111,177,954	$110,920,125	$257,829
	Affiliated Entities and Nonaffiliated Entities			
2	Incentive Payments to Affiliated Parties			
3	Incentive Payments to Nonaffiliated Parties	$0	$847,594	($847,594) [1]
4	Total Incentive Payments	$0	$847,594	($847,594)
	Expenses			
	Medical and Hospital			
5	Inpatient Services - Capitated	$4,232,288	$4,226,956	$5,332
6	Inpatient Services - Per Diem			
7	Inpatient Services - Fee-for-service/case rate	$36,474,646	$33,885,388	$2,589,258 [3]
8	Primary Professional services - Capitated	$37,705,403	$37,567,598	$137,805
9	Primary Professional services - Non-Capitated	$11,764,246	$10,189,193	$1,575,053 [3]
10	Other medical Professional Services – Capitated	$536,341	$6,089,295	($5,552,954) [2]
11	Other medical Professional Services - Non-Capitated	$4,988,542	$0	$4,988,542 [2]
12	Non-Contracted Emergency Room and Out-of-Area Expense, not incl. POS			
13	POS Out-of-Network Expense			
14	Pharmacy Expense	$9,649,178	$9,926,516	($277,338)
15	Other Medical Expense	$1,227,932	$1,227,932	$0
16	Aggregate Write-ins for Other Medical and Hospital Expense			
17	TOTAL MEDICAL AND HOSPITAL	$106,578,576	$103,112,878	$3,465,698
A	**Gross Profit**	**$4,599,378**	**$7,807,247**	
B	**MEDICAL LOSS RATIO** [4]	**95.86%**	**93.73%**	

Note 1: Physician Shared Risk and Physician Incentive payments included on lines 8 and 9 Primary Professional services – Capitated and Non Capitated were reclassified as Incentive Payments to Nonaffiliated Parties. HN-HMO's Physician Shared Risk program aims to involve Participating Provider Groups in effective management of medical costs.

Note 2: Capitation payments for Behavioral Health Services reported on line 11 as Other medical Professional Services - Non-Capitated, were reclassified to line 10 as Other Medical Professional Services – Capitated.

Note 3: The difference in the amount of "Inpatient Services - Fee-for-service/case rate" expense and "Primary Professional services - Non-Capitated" expense $2,589,258 and $1,575,053 respectively are generated from a data compilation methodology. The Balance per DMHC review has been determined based on a historic review of payment data with a look back based on the identified Service Date. The Plan's Schedule 6 methodology is based upon cash payments adjusted for IBNR.

Note 4: Incentive Payments are paid out to Providers based upon a medical performance measurement. They have been considered a valid medical/hospital expense and included in Medical Loss Ratio calculation.

III Summary of Findings

A. HN-HMO reported Total Medical and Hospital expense and Medical Loss ratio as $106,578,576 and 95.86% respectively. The Balance per DMHC review is $103,112,878 and 93.73% respectively. The difference is generated from a data compilation methodology, as was discussed previously in Note # 3 of Table 3. The Balance per DMHC review has been determined based on a historic review of payment data with a look back based on the identified Service Date. The Plan's Schedule 6 methodology is based upon cash payments adjusted for IBNR.

B. Reclassifications were made to the Incentive Payments to Nonaffiliated Parties. Physician Shared Risk and Physician Incentive payments included on lines 8 and 9 Primary Professional services – Capitated and Non Capitated were reclassified as Incentive Payments to Nonaffiliated Parties.

IV Limitations

This analysis and report were prepared solely for the purpose of assisting MRMIB in the determination of the accuracy of payments made by HN-HMO on their Schedule 6 Medical Loss Ratio Report. We have not performed an evaluation of the Company's internal controls within the guidelines set forth by the AICPA but have reported to you based upon the procedures performed. Our analysis has not been a detailed examination of all transactions, and cannot be relied upon to disclose errors, irregularities, or illegal acts, including fraud or defalcations that may exist.

Please feel free to call Anna Belmont, DMHC Examiner with any questions pertaining to this report.

Sincerely,

Anna Belmont, Examiner
Division of Financial Oversight

Stephen Babich, Supervising Examiner
Division of Financial Oversight

cc: Lan Yan, Federal Compliance Unit, MRMIB
Tony Lee, Chief Fiscal Services, MRMIB
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